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ABSTRACT

Following a brief review of literature on marital and family treatment for alcohol problems, this paper describes two types of marital therapy frequently used with alcoholics and presents a brief overview of results from a study in progress comparing the two modalities. Behavioral marital therapy uses communication skills training, contracting, and weekly homework assignments to help couples change specific behaviors in the clinic and at home. Interactional communications-oriented therapy provides feedback on current negative interaction patterns and suggests changes in couple behavior but does not use extensive behavioral rehearsal or specific homework assignments. Couples (N=36), in which the husband had recently begun individual outpatient alcoholism counseling, were randomly assigned to a no-marital-treatment control group or to 10 weekly sessions of either a behavioral or an interactional couples group. Behaviorally treated couples improved more than the other couples on all the marital adjustment measures analyzed and more than the interactional (but not more than control) couples on drinking. In the year after treatment the behavioral group was still superior to the controls on marital adjustment but not to the interactional group and did not do appreciably better than the other two conditions on drinking adjustment. (WAS)

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Marital and Family Therapy for Alcohol Problems

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Marital and Family Therapy for Alcohol Problems

The Second Special Report to the U.S. Congress on Alcohol and Health called marital and family treatment approaches "the most notable current advance in the area of psychotherapy of alcoholism" (Keller, 1974). The enthusiasm for and interest in marital and family therapy for alcoholics derives from a number of converging lines of evidence. Many alcoholics have extensive marital and family problems (Billings, Kessler, Gomberg, & Weiner, 1979; Cvitkovic, 1978; Klein, 1978; Paolino & McCrady, 1977; Woodruff, Guze, & Clayton, 1972). Positive marital and family adjustment is associated with better alcoholism treatment outcomes at follow-up (Bromet & Moos, 1977; Burton & Kaplan, 1968b; Finney, Moos, & Mewborn, 1980; Moos, Bromet, Tsu, & Moos, 1979; Orford, Oppenheimer, Egert, Hensman, & Guthrie, 1976). Disturbed marital and family interaction often precipitates renewed drinking by abstinent alcoholics (Hore, 1971a, b; Marlatt & Gordon, 1978). Finally, recent literature reviews conclude that marital and family therapy have improved alcoholism treatment outcome in several studies(Janzen, 1977; Steinglass, 1976).

Reports on family treatment, which includes family members in addition to the spouse, are very few in number and provide little or no data. Similarly, a recent survey of agencies treating alcohol problems found family treatment practiced very infrequently (Regan, Connors, O'Farrell, & Jones, Note 1). However, a critical review of the existing literature shows that two studies of marital treatment for alcoholics meet the minimal criteria of random assignment to treatment and control groups, at least six months follow-up, and use of specific measures of treatment outcome.

Hedberg and Campbell (1974) compared among alcoholic outpatients the therapeutic efficacy of behavioral marital counseling, systematic desensitization, covert sensitization, and electric shock avoidance conditioning. At six-month follow-up behavioral marital counseling was the most effective treatment for all

patients (regardless of whether the patients' goal was abstinence or controlled drinking) and particularly effective for patients with abstinence goals. Unfortunately, the Hedberg and Campbell outcome data was limited to a global measure of drinking behavior obtained at six-month follow-up.

McCrady and colleagues (McCrady, Paolino, Longabaugh, & Rossi, 1979) in a pilot study randomly assigned persons hospitalized with alcohol problems and their nonalcoholic spouses to one of three treatment groups: (1) joint (husband and wife) hospitalization followed by couples and individual outpatient treatment for both spouses; (2) couples and individual outpatient treatment for both without joint admission; or (3) individual inpatient and outpatient treatment for the patient alone. Couples in groups 1 and 2 were treated in couples groups using a reality-oriented and goal-directed method described as an interactional approach (Blinder & Kirschenbaum, 1976; Gallant, Rich, Bey, & Terranova, 1970; Yalom, 1974). Couples were evaluated at 6-8 weeks and 6-8 months after hospital discharge. All groups showed significant decreases in number of reported marital problems, depression, anxiety, other psychological symptoms and decreased impairment from use of alcohol. Only groups 1 and 2 showed significant decreases in quantity of alcohol consumed although the individuals group also decreased markedly. There were no other significant differences among the three groups, and no significant differences between the joint admission and combined couples and individual groups. Although the McCrady et al. study improves methodologically over previous reports in the literature, conclusions from this study must be tempered by the realizations that there was considerable subject attrition due to incomplete follow-up data, the drinking adjustment measures which assessed only the most recent 30 days have been shown not to be representative of longer time intervals (Cooper, Sobell, Maisto, & Sobell, 1980), and the marital adjustment measures did not include interactional measures (e.g., samples of couple communication) or self-report measures with adequate reliability and validity.

These two controlled studies show that both a behavioral marital therapy in which couples are taught specific communication and behavior change skills and an interactional communications-oriented therapy without specific behavioral teaching and rehearsal produce better drinking outcomes than the comparison treatments evaluated. However, these studies reveal little or nothing about therapeutic effects on the marital adjustment of the couples treated and about the comparative value of the two types of treatment. In addition, neither report describes its treatment methods in detail. The present paper (a) describes these two types of marital therapy in some detail and (b) provides a brief overview of results from a study in progress comparing the effects of the two modalities on drinking and marital adjustment of outpatient alcoholics and their wives.

Interactional Couples Group Treatment

The goals of the interactional (and behavioral) couples group are to decrease conflict about drinking and to increase positive interaction between spouses, effective communication, and resolution of conflicts and problems (about sex, finances, children, leisure time, etc.). To achieve these goals, couples in both types of groups received a pregroup orientation to promote positive expectations and to specify marital issues to be addressed in the groups, feedback on current negative interaction patterns, and suggestions for specific changes in couple behavior. The interactional couples group emphasized catharsis, ventilation, sharing of feelings, problem-solving through discussion, and providing verbal insight on each couple's relationship both from the therapists and from other group members. Therapists planned their strategy for each session in a supervisory conference but did not have a preplanned session outline or detailed treatment manual. Figure 1 summarizes the similarities and differences between the two types of therapy.

Insert Figure 1 about here

Interactional couples group therapy is particularly popular in alcoholism treatment (Steinglass, 1976), has received empirical support (Cadogan, 1973), and

is considered the treatment of choice for married alcoholics by some (Gallant, Rich, Bey, & Terranova, 1970). In a study with nonalcoholic maritally-conflicted couples, Liberman compared interactional and behavioral couples groups and found that both types of couples groups showed significant improvements on the self-report measures, with little or no differences between groups. However, the direct observational data indicated that couples in the behavioral group, as compared to the interaction-insight group, showed significantly more positive and mutually supportive verbal and nonverbal behaviors in their videotaped disucssions after treatment (Liberman, Levine, Wheeler, Sanders, & Wallace, 1976).

Behavioral Couples Group

The behavioral couples group is presented here in some detail because it is more easily specified than the interactional group, and because the major goal of the current study is to evaluate behavioral marital therapy (BMT) with alcoholics. The possible importance of BMT was suggested by a number of converging factors: the behavioral nonmarital treatment of alcoholism currently shows great promise (Marlatt, 1978; Nathan & Briddell, 1977; Sobell & Sobell, 1978); among nonalcoholic populations behavioral approaches to marital therapy are equal or superior to nonbehavioral methods (Jacobson, 1978); and case reports (Eisler, Miller, Hersen, & Alford, 1974; Lazarus, 1965, 1968; Miller, 1972; Murray & Hobbs, 1977; O'Leary & Turkewitz, 1978; Wilson & Rosen, 1976; Emery & Fox, Note 2; Miller & Hersen, Note 3), uncontrolled studies (Azrin, 1976; Cheek, Franks, Burtle, & Laucius, 1971; Hunt Azrin, 1973; Ceek, Burtle, & Laucius, Note 4), and one controlled study (cf. Hedberg & Campbell, 1974, reviewed above) report very good results using behavioral marital therapy with alcoholics (O'Farrell & Cutter, Note 5).

In designing the present behavioral couples group for alcoholics, Peter Miller's (1976) observations on the alcoholic's marriage were used to adapt procedures developed for nonalcoholics by Robert Liberman and his colleagues

(Liberman, et al., 1976; Liberman, Wheeler, & Sanders, 1976). Figure 2 outlines the five modules of the group and indicates that alcohol-related feelings and interactions and daily caring behaviors are dealt with first to decrease tension and build good will for dealing with problems and desired changes later.

Insert Figure 2 about here

Module 1: Alcohol and Alcohol-related Interactions

The goals of this module are to decrease drinking and alcohol-related arguments and interactions during therapy and to maintain these changes after treatment. An Antabuse contract, adapted from the work of Miller (Miller & Hersen, 1975) and Azrin (1976) is used to achieve the first goal. [Antabuse (Disulfiram),a drug which produces extreme nausea and sickness when the person taking it ingests alcohol, is a routine part of the individual alcoholism counseling participated in by all the husbands in the present study.] In the Antabuse contract, illustrated in Figure 3, the husband agrees to take Antabuse each day while the wife observes. The wife, in turn, agrees to record the observation on a calendar provided and not to mention past drinking or any fears about future drinking. We have found it useful to discuss both how to do the contract and how to view the contract. Doing the contract refers to linking the Antabuse observation to a well-established habit such as mealtime or brushing one's teeth, keeping all the materials (calendar, contract, Antabuse tablets) near where the Antabuse is taken and observed, and planning ahead for times when the Antabuse routine most often gets broken such as weekends, vacations, and marital crises. Viewing the contract constructively includes focussing on its individual and couple benefits and being very clear about who has what responsibility. The wife is not responsible for giving the husband his Antabuse; he freely takes the

Antabuse in her presence and she observes this and she freely forgoes talk about drinking. It is extremely important that each spouse view the agreement as a cooperative method for rebuilding trust that has been lost and not as a coercive checking-up operation. With the exception of regular tracking of urges to drink, drinking is downplayed as a topic in the group after the Antabuse procedure has been negotiated.

Insert Figure 3 about here

Drinking becomes a major topic again when the maintenance of therapeutic gains is planned just prior to termination. Husbands and wives complete a work-sheet for homework, adapted from a section of Marlatt's Drinking Profile (Marlatt, 1975), designed to help specify high-risk situations for relapse to drinking that may occur after treatment. Group discussions focus on possible coping strategies the alcoholics and wives can use to prevent or minimize relapse when confronted with these or similar situations

Module 2: Caring Behaviors

The goal of this module is to increase the frequency with which spouses notice, acknowledge, and initiate caring behaviors on a daily basis. Caring behaviors are defined to couples as "behaviors showing that you care for the other person" and a long list of pleasing behaviors taken from the Spouse Observation Check-list (Note 6) is used to give examples. The first session has homework called "Catch Your Spouse Doing Something Nice" to help couples notice the daily caring behaviors that currently occur in the marriage in order to compete with the spouses' tendency to ignore positive and focus on negative behaviors. This technique developed by Turner (Note 7) requires each spouse to write down one caring behavior performed by the partner each day on sheets provided by the therapists (see Figure 4). In session two spouses read the caring behaviors recorded each day of the previous

Insert Figure 4 about here

week. Next, a Communication Session to practice acknowledging caring behaviors is introduced; this is described as important because spouses need to reinforce what they want more of and because it is a first step in opening their hearts to each other again and bringing them closer. Group leaders model acknowledging pleasing behavior noting the importance of eye contact, smile, sincere pleasant tone of voice, and totally positive content. Then each spouse practices acknowledging the two best caring behaviors from his daily list for the previous week. Although this is often very difficult for many couples, repeated role-playing with extensive prompting, coaching and modeling (by the therapists and especially by other group members) is most often successful in instigating the desired behavior. After practicing in the group, homework is assigned for a 2-5 minute Communication Session daily in which each partner acknowledges one pleasing behavior noticed that day.

A final technique in this caring behavior module is the assignment that each partner give the other a Caring Day in the coming week by doing some special things to show caring for the spouse. Couples who engage wholeheartedly in the Caring Day assignment can influence the more negative group members to begin acting more positively toward each other. Discussion often centers on the need to take a risk and act loving toward one's spouse rather than wait for the other to make the first move and to act differenctly and then have the feelings change.

Module 3: Shared Recreational Activities

For homework after the second session, spouses separately list Shared Recreational Activities (SRA) they might like to do with each other. The activity must involve the spouses together, either alone, with their children, or with other adults. When couples report their SRA lists in session 3, therapists often point out that a number of activities appear on the lists of both partners; this is often the case even when a couple has serious conflicts about recreation and rarely can agree

on what to do for fun. The third session's homework assignment is to plan an SRA for the week after next and to report on what they plan to do in the next session. Plans for the coming week are finalized in the next group session with help from the therapists and group members as needed. SRA assignments weekly thereafter are to do the planned SRA and to plan another one for the week after next and report on it the next group session. Each week one spouse is responsible for planning an activity and the other spouse has one veto. The planning role is alternated weekly to show that taking turns is one simple way to resolve conflicts about recreation and also about many other issues.

Currently in our clinical work after the present project we have relabelled this module as Shared Rewarding Activities. This includes activities such as a "date at home" and is not restricted to activities outside the home.

Module 4: Communication Skills Training

Therapists use instructions, modeling, prompting, behavioral rehearsal, and feedback in teaching communication skills of listening, expressing feelings directly, and the use of Communication Sessions. The training starts with nonproblem areas that are positive or neutral and moves to problem areas and charged issues only after each skill has been practiced on less problematic contents.

Communication Sessions. A Communication Session is defined to the couples as a planned, structured discussion in which spouses talk privately, face-to-face, without distractions, taking turns expressing their point of view without interruptions. From session two on Communication Sessions are assigned for homework and the length of session and topic change with the skill being taught. The time and place at which couples plan to have their assigned communication practice sessions is discussed in the group and the success of this plan is assessed at the next session and any needed changes are suggested. In addition to being a vehicle to cue communication practice, a Communication Session is a method couples can use to

exercise stimulus control over their problem solving discussions during and after therapy. Couples are encouraged to ask each other for a Communication Session when they want to discuss an issue or problem and to keep in mind the ground rules of behavior that characterize such a session.

Listening. Listening is a communication skill that helps each spouse feel understood and supported. It slows down couple interactions preventing quick escalation of aversive exchanges, and it is a prerequisite for couple problem solving and couple agreements. The rationale presented to the couples for learning the Listening skills, which borrows heavily from a recent self-help manual on couple communication (Gottman, Notarius, Gonso, & Markman, 1976), begins by defining effective communication as "message intended (by speaker) equals message received (by listener)". Spouses are instructed when in the listener role to repeat both the words and the feelings of the speaker's message and to check to see if the message they received was the message intended by their partner ("What I heard you saying was . . . Is that right?"). When the listener has understood the speaker's message, roles change and the former listener now speaks. Teaching partners in an alcoholic marriage to communicate support and understanding by rephrasing the partner's message before stating one's own position is a major accomplishment that must be carefully shaped. Such learning may be impeded by a partner's failure to separate understanding the spouse's position from agreement with it.

Expressing Feelings Directly. This skill is taught to help couples decrease blaming, hostile, and indirect responsibility-avoiding behaviors in their communication. Since numerous authors indicate that many alcoholic marriages are characterized by the husbands' nonassertive, indirect, responsibility-avoiding style of communication and the wife's hostile, blaming, attacking behavior, learning an alternative to these faulty communication patterns is particularly important Becker & Miller, 1976: Drewery & Rae, 1969; DuHamel, 1971; Gorad, 1971; Gynther & Brilliant, 1967: Mitchell, 1959: Cutler, Note 6).

Learning to express feelings directly is presented to couples as one part of good communication. Couples are instructed that when the speaker expresses feelings directly, there is a greater chance he will be heard because the speaker says these are his feelings, his point of view, not some objective fact about the other person. This reduces listener defensiveness and makes it easier to receive the intended message. The use of statements beginning with "I" rather than "you" is emphasized. After rationale and instructions have been presented, the therapists model correct and incorrect ways of expressing positive and negative feelings and elicit group member's reactions to these modeled scenes. Then couples are instructed to have a "communication session in which you take turns being speaker and listener and practice the speaker expressing feelings directly and listener using the listening response". During this roleplaying, therapists are poised to prompt, model, stop action, and give feedback to couples as they practice reflecting back the direct expressions of owned-to feelings. Similar Communication Sessions, 10 to 15 minutes each three to four times weekly, are assigned for homework after sessions four to six, and more roleplaying practice is done in the group when this homework is discussed.

Modle 5: Making Agreements

By the time this last module is started many changes desired by spouses have been acheived through earlier interventions. What remain often are the deeply conflictual issues in the relationship that each partner feels strongly about and that have been the focus of considerable overt and covert hostility and coercive interaction over the years. Learning to make positive specific requests and to negotiate and compromise are prerequisites in our therapy for making sound behavior change agreements.

Positive specific requests. Initially it is explained that couples often complain about what is wrong and what they are not getting, are vague and unclear about what they want, and try to coerce, browbeat, and force the partner to change.

Couples are told that in order to negotiate or contract for desired relationship changes "each partner has to learn to state his/her desires in the form of : Positive-what you want, not what you don't want; Specific-what, where and when; Requests-not demands which use force and threats but rather requests which show possibility for negotiation and compromise." This notion is illustrated by having the couples consider a list (adapted from Weiss and Ford, Note 9) of 11 requests which are written on the board and on handout sheets given to each spouse. Spouses circle items they think are positive specific requests and then the therapists feedback correct answers to the group on which items meet the criteria and which do not. After discussion, the group members rewrite the incorrect items making them positive and specific. Homework after this session is for each partner to list at least five positive specific requests for changes in their relationship which will be used in the next session.

Negotiation and compromise. To help couples compromise and agree on granting of a stated request, they are instructed to translate each request onto a continuum of possible activities in terms of frequency, duration, intensity or situation rather than present the request in all-or-none terms. Therapists model a Communication Session in which the requests are made in a positive specific form, "heard" by each partner, and translated into a mutually satisfactory, do-able agreement for the upcoming week. Then, using the list of requests completed for homework, each therapist works with a pair of couples to help each couple negotiate an agreement that each partner will fulfill one request in the next week.

Couple agreements. Specific written agreements about desired changes are the focus of much of the later group sessions beginning with a review of the first agreement made in the previous session. After completing agreements in the group under therapist supervision, couples review a handout on the steps involved in making agreements and are asked to have a Communication Session at home to negotiate an agreement on their own and bring it to the following session for review by therapists

and group members. Agreements (see Figure 5 for an example) are of the "good faith" type (Weiss, Birchler, & Vincent, 1974) and external monetary or other reward or punishment contingencies are not used.

Insert Figure 5 about here

Overview of Results of Study in Progress[1]

Design of study

Thirty-six couples, in which the husband had recently begun individual outpatient alcoholism counseling, were randomly assigned to a no-marital-treatment control group, or to 10 weekly sessions of either a behavioral or an interactional couples group. Typically, the couples were high school educated, in their 40's, married 15 years, and had three children. Extensive evidence that the husbands were alcoholics includes previous alcoholism treatment, the presence of withdrawal symptoms, and scores on the Michigan Alcoholism Screening Test (Selzer, 1971).

Male-female cotherapist teams for the two types of couples therapy were similarly experienced and committed to their respective approaches. The behavioral and interactional couples groups were equally credible treatments: couples' responses to a therapy satisfaction questionnaire were highly favorable and revealed no differences between treatments; the mean numbers of sessions attended did not differ between treatments and exceeded 80% of the sessions for both types of groups. The independent variable manipulations were successfully maintained: the amount of therapy contact received by the wife and the couple (other than the assigned couples group participation) was very small as intended and, like the number of individual counseling sessions received by the alcoholic husband, did not differ across the three experimental conditions. The individual alcoholism counseling (the standard clinic program) was done by paraprofessional alcoholism

counselors who provided supportive counseling that encouraged Antabuse, Alcoholics' Anonymous, and abstinence. A large majority of the alcoholics (which did not differ and ranged from 75-90% for the three conditions) were taking Antabuse when they entered the study.

Measures of marital and drinking adjustment were collected pre and post and at 2, 6, 12, 18 and 24-month follow-up periods; and results for the first year after treatment are available currently. To determine whether the behaviorally treated couples improved more than couples receiving interactional or no marital treatment, between-groups planned comparisons of the behavioral treatment with the control and with the interactional treatment were performed using t-tests on the mean scores for each dependent variable (covariance-adjusted by the pre-treatment score) at post and at each follow-up period. In addition, post-hoc comparisons of the interactional with the control group were conducted using the Newman-Keuls procedure. Finally, correlated t-tests within each condition were used to compare pre with post and pre with 12-month follow-up scores to determine whether couples improved significantly from before to after therapy and whether they were still significantly improved one year later.

Results summary

Short-term results from pre to post showed that behaviorally treated couples improved significantly on all marital relationship measures analysed to date including overall adjustment on the Locke-Wallace Marital Adjustment Test (MAT) (Locke & Wallace, 1959), stability on the Marital Status Inventory (MSI) (Weiss & Cerretto, 1980), communication about marriage problems rated from videotaped interaction samples using the Marital Interaction Coding System (Hops, Wills, Patterson, & Weiss, Note 11), and percent of days separated; couples in the other two conditions did not improve significantly on any of these variables. Behavioral group couples improved more from pre to post than control couples for all marital variables and more than interactionally treated couples on all but the MSI and

percent days separated. On drinking adjustment, alcoholics in all three groups improved significantly having considerably less alcohol-involved time (i.e., days drinking or incarcerated in jail or hospital) in the pre to post interval than in the year prior to treatment; and the behavioral group improved more than the interactional group but not more than the controls.

Long term results on marital adjustment in the year after treatment showed: the behavioral group remained significantly improved at 12-month follow-up on the MAT and MSI but not on percent days separated; and no significant gains from pretreatment for the other two groups. The behavioral group was significantly more improved than the controls on the MAT, MSI and time separated, but no longer better than the interactional group on any of the relationship variables studied. On drinking adjustment in the year after treatment: alcoholics in all three groups were significantly improved from the year pretreatment; and the behavioral group was not superior to the control or the interactional conditions.

Both short and long term results showed the interactional group did not differ from the controls on either marital or drinking adjustment.

Discussion

Alcoholic patients and their wives were helped more in their marital relationships when they received behavioral but not interactional marital therapy in addition to the husbands' individual counseling, and this improvement was maintained at one-year follow-up. Demonstrating for the first time that behavioral marital therapy can change the marital adjustment and interactions of alcoholics is important because many marital therapists feel that alcoholism is the most difficult of problems to treat (Geiss & O'Leary, Note 2), it adds to the BMT literature in which most studies have not been done with clinically disturbed samples, and it provides specific treatment procedures that can be used in existing alcoholism programs.

The relative ineffectiveness of the interactional marital therapy was somewhat surprising since this type of therapy produced changes, at least on self-report measures, with nonalcoholics (Liberman et al., 1976). However, with alcoholics the McCrady et al. (1979) study found no advantage of an interactional couples therapy over individual therapy and another previous study (Steinglass, 1979) reported that a more (as compared to a less) directive, structured focused approach to couples therapy seemed more effective. Perhaps just talking about relationship problems without doing anything to make specific changes is no better than no marital therapy at all for alcoholics. It may even stir up problems and lead to more conflict and drinking than if the alcoholic receives only individual counseling. Given that the superiority of the behavioral to the interactional couples treatment on both marital and drinking adjustment in the short run did not endure at one year follow-up, future studies must develop methods for maintaining gains produced by the behavioral therapy before it is the marital treatment of choice to add to outpatient alcoholism counseling.

Surprisingly, adding marital therapy did not provide an advantage for drinking outcomes. The drinking adjustment measure and the method of analysis used in the present study differ extensively from previous studies and may partly account for the different and unexpected results. The drinking variable in the present study does not take into account the amount or consequences of drinking which, given that behaviorally treated alcoholics spent significantly less time separated than the control patients, may turn out to be important factors in additional analyses of the present data. Nonetheless, we did not obtain results favoring the addition of couples treatment for drinking adjustment in the present study. If further analyses confirm this finding, than future studies should pay close attention to marital treatment procedures specifically focused on preventing relapse and maintaining sobriety.

Although this and a few other studies in progress are beginning to accumulate sound data on the use of marital and family therapy with married male alcoholics, studies are almost completely lacking and are needed on adult female alcoholics (Donaburg, Glick, & Fergunbaum, 1977), adolescent alcohol abusers (Stumphauser, 1980), and homosexual couples with alcohol problems (O'Farrell, Note 13). Marital and family treatment procedures for use with alcohol problems that may not warrant a diagnosis of alcoholism and/or may be presented in other than alcoholism treatment settings (e.g., practices of primary care physicians or marriage counselors) also need to be developed and rigorously evaluated.

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Footnotes

[1]The study summarized below was supported by the Veterans Administration and conducted in collaboration with Henry S. G. Cutter. More detailed information is available elsewhere on the treatment techniques (O'Farrell & Cutter, in press) and on the method and results of the research (O'Farrell & Cutter, Note 10).

Figure Captions

Figure 1. Outline of treatment interventions for behavioral and interactional couples groups.

Figure 2. Five modules of behavioral couples group

Figure 3 Sample Antabuse Contract

Figure 4. Sample record sheets of daily caring behaviors completed by couples in behavioral group.

Figure 5. Sample couple agreement

Figure 1

Outline of Treatment Interventions for
Behavioral and Interactional Couples Groups

Interventions	Groups	
	Behavioral	Interactional
1. Orientation to group with instructions to promote therapeutic expectations	Yes	Yes
2. Suggestions to couples for specific behavioral changes at home	Yes	Yes
3. Feedback about negative interactional behavior	Yes	Yes
4. Catharsis, ventilation, sharing of feelings	Limited	Yes
5. Verbal insight on marital relationships	Limited	Yes
6. Antabust Contract	Yes	No
7. Daily record of one Caring Behavior with feedback in group session	Yes	No
8. Planning of Shared Recreational Events weekly with reporting in group session	Yes	No
9. Communication skills training, using behavioral rehearsal, modeling, prompting and feedback	Yes	No
10. Written Couple Agreements (Contracts)	Yes	No
11. Weekly homework assignments and talktime contingency when reporting in group	Yes	No

Figure 2

Five Modules of Behavioral Couples Group

1. Alcohol and Alcohol-Related Interactions
   - A. Antabuse Contract
   - B. Discussions about preventing/coping with relapse

2. Caring Behaviors
   - A. Catch your spouse doing something nice
   - B. Caring Days

3. Shared Recreational Activities

4. Communication Skills Training
   - A. Listening
   - B. Expressing feelings directly
   - C. Communication sessions

5. Making Agreements
   - A. Positive specific requests
   - B. Negotiating and compromising
   - C. Couple agreements

Figure 3

ANTABUSE CONTRACT

In order to help John Doe with his own self-control and to bring peace of mind to Mary, his wife, John + Mary Doe agree to the following arrangement.

John's Responsibilities	Mary's Responsibilities
1. Takes Antabuse each day at night before bed.	1. Observes the Antabuse being taken and records that she observed it on the calendar provided.
2. Thanks wife for observing the Antabuse.	2. Thanks husband for taking the Antabuse and shows her appreciation when he takes it.
3. If necessary, request that wife not mention past drinking or any fears about future drinking.	3. Does not mention past drinking or any fears about future drinking.
4. Refills Antabuse prescription before it runs out.	4. Reminds when prescription needs refilling.

EARLY WARNING SYSTEM: If at any time, Antabuse is not taken for 2 days in a row, John or Mary should contact Dr. O'Farrell (583-4500, Ext. 481 or Ext. 465) immediately.

LENGTH OF CONTRACT: This agreement covers the time from today until October 9, 1980. It cannot be changed unless all three parties discuss the changes in a fact-to-face meeting of at least 30 minutes.

Date 10/9/79 John Doe Mary Doe

Timothy O'Farrell

Figure 4

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"CATCH YOUR SPOUSE DOING SOMETHING NICE"

NAME: Mary NAME OF SPOUSE: John

DAY	DATE	PLEASING BEHAVIOR
MON.	10/8	He emptied dishwasher and folded clothes after I went to bed early because I didn't feel good.
TUES.	10/9	Brought home a rose for me.
WED.	10/10	John cleaned up after supper so I could get an early start on food shopping.
THUR.	10/11	Gave me extra money for myself.
FRI.	10/12	Called me during the day and told me how much he loved me.
SAT.	10/13	He watched the kids in the morning so I could get my hair done.
SUN.	10/14	John told me I looked nice when I got dressed to go to church.

Figure 4 (cont.)

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"CATCH YOUR SPOUSE DOING SOMETHING NICE"

NAME: John NAME OF SPOUSE: Mary

DAY	DATE	PLEASING BEHAVIOR
MON.	10/8	Mary made my favorite supper.
TUES.	10/9	She put the storm windows on the windows and doors so I would have more time on Sat.
WED.	10/10	Told me she loved me.
THUR.	10/11	Got up and fixed breakfast for me even though she was up late the night before.
FRI.	10/12	After I came home from work she filled the tub and we jumped in together, etc! (The kids were at her mother's.)
SAT.	10/13	Mary came out and looked at the work I had done in the yard and told me how nice it looked.
SUN.	10/14	Made coffee and talked with me for an hour.

Figure 5

COUPLE AGREEMENT RECORD

Name: John & Mary Doe Week Beginning 10/10/79 (Wed)

John's RESPONSIBILITIES (Mary checks when performed)

1. Go to look at refrigerator on Friday night
2. Take Mary to movie of her choice on Saturday
3.

DAY						
Wed	Thurs	Fri	Sat	Sun	Mon	Tues
		✓				
			✓			

Mary's RESPONSIBILITIES (John checks when performed)

1. Serve dinner in kitchen three nights this week
2. Sit down for 15 minute Communication session after
3. supper each night

W	Th	F	S	S	M	T
✓	✓				✓	
✓	/	✓			✓	

RETURN THIS FORM TO LEADER OF CLASS ON ALCOHOL AND MARRIAGE AT NEXT MEETING.

SIGNED: John Doe and Mary Doe

DATE: 10/9/79